

IN THE MUNICIPAL COURT OF DARKE COUNTY, OHIO
CIVIL DIVISION

Name: _____

Case No. _____

Address: _____

BMV Case No. _____

City: _____

SSN#: _____

DOB: _____

Phone: _____

Plaintiff,

vs.

COMPLAINT TO SET ASIDE OR MODIFY SUSPENSION

MIKE RANKIN
Bureau of Motor Vehicles
P.O. Box 16520
Columbus, Ohio 45316

Defendant.

1. Now comes Plaintiff, _____, and states that they received a letter suspending their driver's license, effective on _____.
2. Plaintiff can show cause why suspension should be set aside or modified.
3. Plaintiff agrees to pay court costs.

The State of Ohio, Darke County, ss:

_____ being duly sworn says that they are Plaintiff in the within entitled cause, and that the facts stated in the foregoing complaint are true.

Signature of Plaintiff

Sworn to before me and signed in my presence this _____ day of _____, _____.

Clerk/Deputy Clerk

APPLICATION FOR DRIVING PRIVILEGES

Case Number: _____

Pending Case

Full Name: _____

Post-Conviction
(\$25 Fee Due at
time of Filing)

Residence Address: _____

Phone Number: _____ Cell: _____

Proof of
Auto Insurance

Email Address: _____

I wish to apply for **limited** driving privileges (complete applicable sections below)

1.) Primary Employment:

Employer: _____

Proof from
Employer with
days & hours
worked attached

Employer Address: _____

Employer Phone: _____

2.) Secondary Employment:

Employer: _____

Proof from
Employer with
days & hours
worked attached

Employer Address: _____

Employer Phone: _____

Employment letter must be on letter head and signed by employer.

Letter needs to state days/hours worked, whether employee is required to drive during work hours
and if overtime is mandatory or volunteer based.

3.) Education & Vocational Purposes:

School Name: _____

Proof from
School of days &
hours of classes
attached

Address: _____

Phone: _____

APPLICATION FOR DRIVING PRIVILEGES

4.) Medical and/or Treatment Programs, including AA, MADD, Counseling, IOP, Aftercare:

Medical: _____

Outpatient Treatment: _____

Aftercare: _____

AA/MADD: _____

Counseling: _____

Other: _____

**Proof from
Medical
Professional
and/or Treatment
agency of days &
hours of treatment**

Do you live alone? YES or NO

5.) Driving for Necessities - Choose one 3-Hour Window, same day/time every week:

Note the day and 3 hour window you wish to drive for necessities
(Church, Shopping, Haircut, Bank, Gas, etc.)

6.) Other:

Name: _____

Address: _____

Phone: _____

Please explain: _____
